IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WISCONSIN

CODY FLACK, SARA ANN MAKENZIE, MARIE KELLY, and COURTNEY SHERWIN,

Plaintiffs,

v. Case No. 18-CV-0309

WISCONSIN DEPARTMENT OF HEALTH SERVICES and ANDREA PALM, in her official capacity as Secretary-Designee of the Wisconsin Department of Health Services,

Defendants.

DEFENDANTS' RESPONSE TO PLAINTIFFS' PROPOSAL FOR EQUITABLE RELIEF

Defendants Wisconsin Department of Health Services (DHS) and Andrea Palm, in her official capacity as DHS Secretary-Designee (collectively "Defendants"), submit this response to Plaintiffs' [Proposed] Order Granting Permanent Injunctive and Equitable Relief. (Dkt. 225-1.)

INTRODUCTION

Plaintiffs' proposal for permanent equitable relief should not be entertained by this Court. It essentially would have this Court run DHS's Medicaid program in various respects and to do so in many unworkable ways,

and all of it is unmoored from what is appropriate or necessary as relief. It proposes an expansive permanent injunction, notice to various individuals, medical entities, and social organizations, and reporting requirements to the Court for up to 1 ½ years after final judgment. None of this is necessary. The only issue, in this case, was the validity of the Challenged Exclusion. Nothing in either Plaintiffs' complaint or the Court's decisions address the necessity of adopting specific insurance coverage guidelines for gender dysphoria treatments, an affirmative obligation to use any particular "prevailing standards of care" when evaluating Medicaid coverage requests, or Defendants' contractual obligations with third-party HMOs. As a result, Plaintiffs' remedial plan requiring Defendants to articulate, publish, notice, and report these efforts to the Court is beyond the scope of the issues actually litigated in this case. Removal of the Challenged Exclusion is the only appropriate remedy.

Moreover, many of the specific proposals are overly broad and vague and require a departure from generally applicable Wisconsin Medicaid procedures. Under Fed. R. Civ. P. 65(d), any injunctive relief ordered by the Court must state its terms specifically, describe in reasonable detail the acts restrained or required, and cannot refer to other documents. Plaintiffs' proposal fails to abide by these requirements in several respects. For instance, it incorporates discretionary medical treatment guidelines that do not necessarily provide

clear answers about specific medical necessity decisions, and it requires notice to DHS employees who have nothing to do with the Challenged Exclusion and the administration of Medicaid benefits. In these ways and more, Plaintiffs' proposal violates the basic requirements of Rule 65(d) and should not be adopted by the Court.

ADDITIONAL FACTS

A. Notice that the Challenged Exclusion was no longer enforceable.

After the Court issued the preliminary injunction enjoining class-wide enforcement of the Challenged Exclusion in this case, on April 29, 2019, Makalah Wagner–Managed Care Section Chief for the DHS Division of Medicaid Services (DSM), Bureau of Benefits Management (BBM)–sent an email to all Medicaid HMO contract administrators notifying them of the Court's order. (Decl. of Pamela Appleby, Sept. 24, 2019, ¶ 10 (hereafter "Appleby Decl.")) Shortly thereafter, on May 9, 2019, DHS held a meeting for all Medicaid HMO contract administrators. (Appleby Decl. ¶ 11.) At this meeting, the BBM Associate Bureau Director Pamela Appleby addressed the Court's preliminary injunction order with these Medicaid HMOs contract administrators. (*Id.*)

BBM staff also continues to field and respond to individual questions from Medicaid HMOs regarding coverage for gender-confirming surgery.

(Appleby Decl. ¶ 13.) BBM has consistently advised these HMOs that it must not deny transgender surgeries solely on the basis of the Challenged Exclusion and that they must make their own medical necessity determination for requested services. (*Id.*)

In addition to notifying the Medicaid HMOs, DHS also updated its "LGBT Health-Transgender Persons" web page after the Court issued its April 23, 2019, preliminary injunction. (Appleby Decl. ¶ 12.) Any reference to the Challenge Exclusion was removed. (*Id.*)

B. Processing requests after removal of the Challenged Exclusion.

Wisconsin Medicaid beneficiaries are provided medical assistance for various covered services. (Appleby Decl. ¶ 5.) If prior authorization is required for coverage of a given treatment or service, whether traditional Medicaid fee-for-service or Medicaid HMOs, any coverage approval is subject to Wisconsin Medicaid's standard review, prior authorization procedures, and determinations for medical necessity under Wis. Admin. Code DHS § 101.03(96m). (*Id.*) Allowing any class of Medicaid beneficiaries to bypass this standard approval process would result in preferential treatment for that class, different from all other Medicaid participants. (*Id.*)

DHS aims to provide Wisconsin Medicaid beneficiaries with medically necessary covered services for the treatment of gender dysphoria. (Appleby

Decl. ¶ 6.) While DHS intends to review requests for these services under prevailing standards of care–such as those published in guidelines by the World Professional Association for Transgender Health (WPATH) and the Endocrine Society–DHS cannot be limited to those two guidelines (including unknown future versions of those guidelines, as Plaintiffs request). (*Id.*) Wisconsin Medicaid providers and reviewers must have the flexibility to make coverage decisions based on evolving standards of care and professional judgment, especially in the area of gender dysphoria. (*Id.*)

DHS will formulate coverage policy for gender-confirming treatments previously excluded under the Challenged Exclusion, but this process should not and cannot be rushed. (Appleby Decl. ¶ 7.) DSM's Bureau of Benefits Management must first request input from its clinical partners, including contracted health plans, to ensure that the coverage policy is responsive to their needs. (Appleby Decl. ¶ 8.) BBM also conducts other research and reviews various professional guidelines and standards of care. (*Id.*) A draft coverage policy that results from this process then must undergo multiple levels of review and approval within DHS before publication. (*Id.*) While it would be possible to develop the coverage policy itself within 120 days, it would take at least 180 days to fully integrate this policy into the Medicaid program. (*Id.*) This is because full integration would include changes to the program's coding

system and electronic claims and financial systems, which must be done through an outside contractor. (*Id.*)

Further delay is possible because BBM coverage policies are considered "guidance documents" that are subject to the publication, notice, and public comment provisions in Wis. Stat. § 227.112. (Appleby Decl. ¶ 9.) This newly-enacted requirement will add additional time to the process. (*Id.*) However, DHS believes it can accomplish these requirements within the 180 days needed to draft the coverage policy and fully operationalize this policy into the Medicaid program. (*Id.*)

When DHS implements a new covered service or benefit, DHS includes BadgerCare Plus and Medicaid SSI HMOs in the distribution of Forward Health provider updates regarding the implementation of the benefit, including coverage policies. (Appleby Decl. ¶ 14.) When BBM completes a coverage policy for gender-confirming services previously subject to the Challenged Exclusion, that policy will be distributed to contracted BadgerCare Plus and Medicaid SSI HMOs. (*Id.*) Distribution of coverage policy through Forward Health provider updates to enrolled Forward Health providers and contracted health plans is an established DMS process. (*Id.*) In addition, the Forward Health online provider handbook is updated as coverage policy changes. (*Id.*) The online provider handbook is an available reference to any

member of the public with access to the internet. (*Id.*) Separate notice of this coverage policy to new Medicaid HMOs would, therefore, be unnecessary. (*Id.*)

DMS and the various offices within DHS involved in the administration of Wisconsin Medicaid number approximately 1000 employees. (Appleby Decl. ¶ 15.) Hundreds of these employees have no involvement in the administration of Medicaid benefits. (*Id.*) For example, DMS employees conducting Medicaid eligibility determinations or processing federal payment requests would have no reason to be advised of a change in coverage for gender-confirming treatments, as these employees do not work with or advise on Medicaid benefits. (*Id.*) As such, notice of any coverage changes and policies would only be provided to DHS staff involved with Medicaid benefits administration. (*Id.*)

C. *ForwardHealth Update* 2010–20.

ForwardHealth Update is an electronic service administered by DHS that provides program policy and billing information for Wisconsin Medicaid providers, including HMOs. (Appleby Decl. ¶ 16.) It would take approximately 120 days to issue a *ForwardHealth Update*. (*Id.*) This is because these updates are the product of a collaborative effort across several sections and divisions that require multiple resources and pass various levels of internal review. (*Id.*) It is likely that the update also would be considered a "guidance document" that would have to go through the notice-and-comment process outlined in Wis. Stat. § 227.112 and mentioned above. (*Id.*)

ForwardHealth Update, No. 2019-20, titled "Transgender Surgery Policy" was developed by June 2019. (Appleby Decl. ¶ 17.) It provides information to Medicaid providers regarding the Court's preliminary injunction order. (*Id.*) Because this update was considered a guidance document, it came under the publication and public comment requirements of Wis. Stat. § 227.112. (*Id.*) It was published by the Legislative Reference Bureau (LRB) on July 8, 2019, marking a beginning of a 21-day public comment period before certification under Wis. Stat. § 227.112. (*Id.*) Thus, the update was held to accommodate public comment. (*Id.*)

ForwardHealth Update 2019–20 contains fee-for-service policy and applies to services Medicaid beneficiaries receive on a fee-for-service basis. (Appleby Decl. ¶ 18). But all Wisconsin Medicaid HMOs are required to provide at least the same benefits as those provided in this *ForwardHealth Update* under fee-for-service arrangements. (*See* Dkt. 227-2.)

D. Medicaid HMOs

Medicaid HMOs need not report to DHS when they deny a member's prior authorization request. (Appleby Decl. ¶ 22.) If an HMO denies coverage for gender-confirming surgeries after the Challenged Exclusion was enjoined, DHS only becomes aware of the denials if and when the beneficiary appeals the decision or otherwise submits it to DHS for a second-tier review. (*Id.*)

Since the Court's preliminary injunction order in this case, DHS has overturned an HMO's denial of gender-confirming surgery. (Appleby Decl. ¶ 23.) There is also a fair hearing currently scheduled for another HMO's service denial for gender-confirming surgery. (*Id.*) DHS has upheld one HMO's denial of gender-confirming surgery because the provider in that case failed to provide adequate medical necessity documentation. (*Id.*)

Quartz, a Wisconsin Medicaid HMO, should not be applying a pre-determined list of excluded services when making coverage determinations for requests for gender-confirming surgery for Medicaid beneficiaries. (Appleby Decl. ¶ 24.) *ForwardHealth Update* 2019–20 instructed Medicaid HMOs that previously excluded gender-confirming surgery services will now be allowable with prior authorization, and prior authorizations for these surgeries must be reviewed on a case-by-case basis. (Dkt. 227-2:3.) Again, while the *ForwardHealth Update* addresses fee-for-service policy, it expressly states that Medicaid HMOs "are required to provide at least the same benefits as those provided under fee-for-service arrangements." (*Id.* quoting Dkt. 227-2:3.) Quartz's pre-determined list of excluded services is not in accordance with DHS intent when providing guidance that health plans should make individualized determinations of the medical necessity of services for a Medicaid member. (*Id.*)

DHS sets Medicaid HMO coverage policy and has contract oversight, along with second-tier review of coverage decisions. (Appleby Decl. ¶ 25.) If a Medicaid HMO improperly denies coverage to a Medicaid beneficiary, DHS will overturn the denial through the grievance process, which includes a second-tier review. (*Id.*)

E. Identifying and notifying past beneficiaries and providers denied coverage under the Challenged Exclusion.

Most Medicaid beneficiaries who were previously denied coverage under the Challenged Exclusions and their medical providers are unknown to DHS. (Appleby Decl. ¶ 19.) This is because Medicaid HMOs were responsible for most such denials and they did not come to DHS's attention. The only denials that DHS would know about include fee-for-service beneficiaries, beneficiaries involved in the DHS grievance process, or beneficiaries specifically brought to the attention of DHS through other means. (*Id.*)

It would be difficult to identify these individuals and providers because DHS has no universal method of flagging that a person is seeking a specific procedure as treatment for gender identity disorder, gender dysphoria, or transsexualism. (Appleby Decl. ¶ 20.) While DHS is aware that some past requests had been flagged as related to "gender identity" or "transsexualism," providers did not need to submit prior approval requests with that kind of detail, and so DHS cannot know the entire universe of denied requests. (*Id.*)

For those individuals and providers that DHS can identify, it is likely that notices in the form proposed by Plaintiffs would be considered a guidance document under Wis. Stat. § 227.01(3m), triggering the notice, publication, and public comment requirements in Wis. Stat. § 227.112. (Appleby Decl. ¶ 21.) If they are guidance documents, DHS has indicated that can complete this process within 90 days after these notices were drafted. (*Id.*)

ARGUMENT

I. Under the applicable legal standard, declaratory relief is preferable, and any injunction must be no broader than the violation.

A. Declarations are preferred remedies in cases like this one.

As Defendants explained in their brief in support of their proposed remedial plan, "[i]f the entry of a regulatory injunction can be avoided by a simpler declaratory judgment, everyone comes out ahead." (Dkt. 224:3–4 (citing *Badger Catholic, Inc. v. Walsh*, 620 F.3d 775, 782 (7th Cir. 2010)). A declaratory judgment, alone, fixes the defendants' legal obligations, without any need for a corresponding injunction. *See U.S. v. P.H. Glatfelter Co.*, 768 F.3d 662, 682 (7th Cir. 2014). As explained in more detail below, Plaintiffs have offered no evidence suggesting that Defendants will fail to comply with a declaration that the Challenged Exclusion is unlawful, such that a coercive injunction is necessary.

B. Any injunction must be no broader than the violation.

Even if this Court concludes that an injunction is appropriate, it does not have unlimited equitable authority to craft whatever relief it chooses. "Once a constitutional violation is found, a federal court is required to tailor 'the scope of the remedy' to fit 'the nature and extent of the constitutional violation.'" *Hills v. Gautreaux*, 425 U.S. 284, 293–94 (1976) (citation omitted); *see also Califano v. Yamasaki*, 442 U.S. 682, 702 (1979) ("injunctive relief should be no more burdensome to the defendant than necessary to provide complete relief to the plaintiffs"). That is in part because an injunction is an "extraordinary remedy" whereby a court "directs the conduct of a party . . . with the backing of its full coercive powers." *Nken v. Holder*, 556 U.S. 418, 428 (2009) (citation omitted). Therefore, although "[a] district court ordinarily has wide latitude in fashioning injunctive relief," "a court abuses its discretion where the scope of injunctive relief 'exceed[s] the extent of the plaintiff's protectible rights.'" *PepsiCo, Inc. v. Redmond*, 54 F.3d 1262, 1272 (7th Cir. 1995) (citation omitted) (second alteration on original).

That rule against overbroad injunctions has two key corollaries. First, if a plaintiff does not challenge a specific policy or practice as unlawful in their complaint, an injunction cannot bar that policy or practice. *See, e.g.*, *Church of Holy Light of Queen v. Holder*, 443 F. App'x 302, 303, 2011 WL 2784084, at *1 (9th Cir. 2011) (vacating injunction that applied "beyond the scope of the

complaint and enjoins government regulations that were explicitly never challenged or litigated"); *Thomas v. Cty. of Los Angeles*, 978 F.2d 504, 510 (9th Cir. 1992), as amended (Feb. 12, 1993) (vacating injunction that applied "even broader than the scope of plaintiffs' complaint"); *Sprint Sols., Inc. v. Cell Wholesale, Inc.*, No. 15-CV-878, 2016 WL 875384, at *2 (C.D. Cal. Mar. 7, 2016) (rejecting proposed injunction against "innocuous or unrelated activities" because it "extend[ed] beyond the scope of unlawful conduct").

Second, even if the complaint challenges a practice, it cannot be subject to a permanent injunction unless the plaintiff proves that the practice was unlawful and caused injury. For instance, in *Lewis v. Casey*, 518 U.S. 343 (1996), the plaintiffs proved at trial that a prison system's failure to provide adequate legal services for illiterate inmates violated their constitutional right of access to the courts. A corresponding injunction ordered changes in those services, but it also directed a variety of other reforms, including access to the law library by the general population and inmates on lockdown. The Court "eliminate[d] from the proper scope of [the] injunction" these other provisions, because "they [had] not been found to have harmed any plaintiff in this lawsuit, and hence were not the proper object of this District Court's remediation." *Id.* at 358; *see also Dayton Bd. of Ed. v. Brinkman*, 433 U.S. 406, 417 (1977) ("[I]nstead of tailoring a remedy commensurate with the three specific

violations, the Court of Appeals imposed a systemwide remedy going beyond their scope.").

A similar principle applies to broad injunctions when applied to lawful activity by parties who have not demonstrated a pattern of willful misconduct. *See, e.g., Beastie Boys v. Monster Energy Co.,* 87 F. Supp. 3d 672, 681 (S.D.N.Y. 2015) (finding injunction overbroad based on "transgressions that [were] unlikely to recur").

II. Plaintiffs' proposed remedial plan is overly broad, vague, and extends far beyond the basis for this Court's liability finding.

A. This litigation and the Court's summary judgment order focused on the validity of administrative code provisions.

From the start, this case has been about one thing and one thing only: whether provisions in Wisconsin's administrative code regarding Medicaid coverage policies for certain gender dysphoria treatments—specifically, Wis. Admin. Code DHS §§ 107.03(23)–(24) and 107.10(4)(p)—comply with federal law. (*See* Dkt. 1:2–3 ¶ 2 (original complaint); Dkt 85:1 ¶ 1 (first amended complaint); 189-1:2 ¶ 1 (second amended complaint).) The causes of action have always focused on the validity of those specific provisions. (Dkt. 1:27–29 ¶¶ 107, 110, 112, 114–15; Dkt. 85:38–40 ¶¶ 153, 156, 158, 160–61; Dkt. 189-1:39–41 ¶¶ 153, 156, 158, 160–61.) Nothing in Plaintiffs' complaint addressed the necessity of adopting specific insurance coverage guidelines for the affected treatments, an affirmative obligation to use any

particular "prevailing standards of care" when evaluating coverage requests, or the Defendants' contractual obligations with third-party Medicaid HMOs.

It is therefore unsurprising that this Court's summary judgment decision addressed only the validity of the challenged administrative code provisions. On each claim—under the Affordable Care Act, the Medicaid Act, and the Equal Protection Clause—this Court very specifically held that the "Challenged Exclusion" was unlawful. (Dkt. 217:24, 32, 37.) It did not find unlawful any other action (or inaction) by Defendants. That is, this Court's decision did not hold that Defendants violated federal law by engaging in an informal pattern of discretionary acts. Nor did the Court conclude that any lack of coverage guidelines, failure to use any "prevailing standards of care," or contractual relationships with HMOs violated federal law. Rather, it found that Defendants violated federal law only by promulgating—decades earlier—and following a specific administrative code provision that categorically barred Medicaid coverage for "transsexual surgery" and related pharmaceutical treatments.

Moreover, this Court's theory of liability on each claim is also crucial to any permissible injunctive remedy here. On each theory, this Court held that the Challenged Exclusion was unlawful to the extent it treated Medicaid beneficiaries with gender dysphoria differently from all other beneficiaries. That is, if Defendants covered a treatment when prescribed for a diagnosis

other than gender dysphoria, this Court held that they could not categorically ban coverage for that same treatment when prescribed *for* gender dysphoria. (Dkt. 70:25–26, 29; Dkt. 217:24, 32–34.) This Court did not hold, however, that Defendants violated federal law by declining to cover a treatment for *all* Medicaid beneficiaries. If no Medicaid beneficiary receives coverage for a treatment, there is no unlawful discrimination under the Court's order.

Given the scope of the complaint and the Court's decision, any injunction in this case can only target enforcement of the Challenged Exclusion itself. Plaintiffs have not established a right to any other action by Defendants, and so an injunction can do nothing more than bar them from enforcing the Challenged Exclusion.

B. Plaintiffs' cases are largely inapposite because they involved systemic violations resulting from discretionary acts.

Before addressing each element of Plaintiffs' proposed remedial plan, it is worth considering why the cases they cite are generally inapposite here. (*See* Dkt. 226:11–13.) In short, almost all involve broad, structural constitutional violations resulting from discretionary behavior by government officials. With one exception, none involved a challenge to a specific policy promulgated in a statute or administrative rule, unlike this case. In those other cases that involved broad constitutional violations resting on discretionary conduct, broad remedies were deemed appropriate. But in this

case, which focuses on the validity of a specific policy enshrined in law, Plaintiffs offer no authority for the proposition that a court's equitable relief extends beyond invalidating that specific policy.

First, they rely on racial desegregation cases, which are very different from this one. They cite *Swann v. Charlotte-Mecklenburg Board of Education*, 402 U.S. 1, 15 (1971), for the proposition that "[o]nce a right and a violation have been shown, the scope of a district court's equitable powers to remedy past wrongs is broad, for breadth and flexibility are inherent in equitable remedies." But that was a school desegregation case, which the Court recognized presented "an area of evolving remedies" where district courts "had to improvise and experiment without detailed or specific guidelines" in order to "eliminate dual systems and establish unitary systems at once." *Id.* at 5. In desegregation cases, there is no single, formal policy at issue. Rather, the issue is whether public schools retain a "vestige[ ] of state-imposed segregation" and, if so, how to achieve desegregation. Likewise, *Hills*, 425 U.S. 284, 297–300, addressed discriminatory practices that led to public housing segregation—reversing the widespread discretionary practices that led to housing segregation required a broad remedy.

Much like the desegregation cases, Plaintiffs also cite *United States v. Paradise*, 480 U.S. 149 (1987), a case about Alabama's four-decade-long informal practice of declining to hire black applicants as state troopers. Given

that entrenched and clearly unconstitutional practice, the Court approved a remedial plan that affected both hiring and promotions. The United States challenged the promotion-focused remedies as beyond the scope of the admitted hiring violation, but the Court noted that promotion had "been a central concern of the District Court since the commencement of this action" and approved a remedy also targeted at discriminatory promotional practices. Again, *Paradise* involved a series of discretionary acts by individual government officials intentionally discriminating.

Plaintiffs also rely on prison overcrowding cases, which also do not involve any specific policy memorialized in law like the one here. *Brown v. Plata*, 563 U.S. 493 (2011), addressed whether the California prison system was so overcrowded that it necessarily violated inmates' Eighth Amendment right to adequate medical and mental health care. *Id.* at 499–502. Because the Court agreed that overcrowding was the "primary cause" of the constitutional violations (*id.* at 517–26), it agreed that only an order directing California to reduce the total prison population could remedy the overcrowding violation (*id.* at 527–38). The same analysis was applied in *French v. Owens*, 777 F.2d 1250, 1253 (7th Cir. 1985), another prison overcrowding case. Like in the desegregation and hiring cases, the remedies in these overcrowding cases needed to be broad given the informal practices that produced structural unconstitutional results.

Similarly, in *Ollier v. Sweetwater Union High School District*, 858 F. Supp. 2d 1093, 1110–12 (S.D. Cal. 2016), the Title IX violations included informal practices related to a wide range of sports activities, such as recruiting benefits, practice facilities, equipment, and coaching. Given the wide-ranging activities that formed the basis for the Title IX violations, the district court imposed a compliance plan that affected each area and ongoing court monitoring. *Id.* at 1115–16. The Court here, by contrast, found no such wide-ranging violations resulting from informal practices.

Unlike those cases, this case involves three specific administrative code provisions that this Court held violate federal law. This Court did not identify any widespread discretionary practices by Defendants or any other officials within DHS that caused discrimination in the way that, for instance, such practices produced unlawful segregation in *Swann* or prison overcrowding in *Brown*. Rather, the only discrimination the Court found here was that specifically directed by the challenged administrative code provisions. Therefore, the only possible valid remedy is declaring the administrative code provisions unlawful (and, perhaps, enjoining their enforcement). None of Plaintiffs' cited cases provide authority for a broader structural remedy, because no broad discretionary practices produced the violation here.

The only case that Plaintiffs cite arguably resembling this one is *K.G. ex rel. Garrido v. Dudek*, 981 F. Supp. 2d 1275 (S.D. Fla. 2013), where a district

court invalidated a state's administrative rule that barred Medicaid coverage for certain autism treatments. But there, the court drew a fairly narrow remedy that enjoined the challenged rule and directed the state to provide the treatment at issue to the named plaintiffs and to provide some notifications to health care providers. *Id.* at 1289. The court did not, however, order the agency to cover any treatments other than the specific ones at issue in the case, publish coverage criteria, or enter into new contractual arrangements with third parties. *Id. Garrido*, therefore, does not stand for the proposition that invalidating a specific administrative insurance coverage provision permits a court to use its equitable authority to restructure a state's Medicaid program more broadly.

C. The proposed remedial plan extends far beyond the basis for this Court's liability finding and violates Fed. R. Civ. P. 65(d).

1. Plaintiffs' proposed definitions

The overbreadth of Plaintiffs' proposed permanent injunctive relief begins in the "Definitions" section of their proposed order. (*See* Dkt. 225-1:2–4.) Plaintiffs' proposed definition of "gender dysphoria" is not consistent with this Court's findings in its summary judgment decision, where it adopted the following definition from the DSM-5:

> *Gender dysphoria* refers to the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender. Although not all individuals will experience distress as

> a result of such incongruence, many are distressed if the desired physical interventions by means of hormones and/or surgery are not available. The current term is more descriptive than the previous DSM-IV term *gender identity disorder* and focuses on dysphoria as the clinical problem, not identity per se.

(Dkt. 217:3.) Instead, Plaintiffs include an expanded definition that "also refers to related diagnoses in current, previous, or future editions" of the DSM and the International Classification of Diseases—a reference not acknowledged by any of the Court's orders.

Plaintiffs' definition of "gender-confirming treatment" also effectively expands the scope of permanent injunctive relief beyond the issues litigated in this case. Plaintiffs define it as "any surgical, hormone treatment, *or related service for the treatment of gender dysphoria.*" (Dkt. 225-1:3 (emphasis added).) But this definition exceeds the scope of procedures and treatments previously prohibited under the Challenged Exclusion—that exclusion only applied to surgical and hormone treatments. The Court acknowledged as much, explaining that "the issue of fact here [is] whether gender-confirming surgery and related hormones are now a generally accepted form of medical treatment for gender dysphoria." (Dkt. 217:22.) Plaintiffs' definition would go much farther by requiring coverage of gender-confirming treatments such as laser hair removal, voice therapy, and penile prosthetics, treatments that were not subject to the Challenged Exclusions and, thus, are beyond the scope of the issues addressed by the Court's findings.

Plaintiffs' proposed definitions also seek to establish "prevailing standards of care" for the treatment of gender dysphoria as set forth in guidelines published by WPATH and the Endocrine Society, and "future versions of those documents." (Dkt. 225-1:3.) However, neither of these documents set forth a clear and unambiguous course of treatment for individuals with gender dysphoria. As the Court noted, both of these documents are *guidelines*, not standards of care, as even these two bodies admit. (Dkt. 217:4.)

WPATH also explains that its guidelines "are intended to be flexible in order to meet the diverse health care needs of transsexual, transgender, and gender-nonconforming people." World Professional Association of Transgender Health, *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*, 2 (7th Version 2011), https://www.wpath.org/media/cms/Documents/SOC%20v7/Standards%20of%20Care_V7%20Full%20Book_English.pdf (hereafter "WPAPTH Guidelines"). The WPATH guidelines note further that "individual health professionals and programs may modify them" and expressly contemplate "[c]linical departures" from the guidelines. (WPATH Guidelines 2.) The guidelines stress that "[t]reatment is individualized: What helps one person alleviate gender dysphoria may be very different from what helps another person." (WPATH Guidelines 5.)

The Endocrine Society guidelines similarly caution over-restricting treatment for gender dysphoria to a single standard of care:

> The guidelines should not be considered inclusive of all proper approaches or methods, or exclusive of others. The guidelines cannot guarantee any specific outcome, *nor do they establish a standard of care*. The guidelines are not intended to dictate the treatment of a particular patient. Treatment decisions must be made based on the independent judgment of healthcare providers and each patient's individual circumstances.

Wylie C. Hembree, et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline, J. Clin. Endocrinol Metab.*, November 2017, at 3895 (emphasis added) (hereafter "Endocrine Society Guidelines").

Because Plaintiffs' definition of "prevailing standard of care" is not consistent with the Court's findings and also references documents that expressly do not provide fixed standards of care, it should be rejected. Medical and mental health professionals who participate in Wisconsin Medicaid must be able to exercise their independent professional medical judgment when evaluating treatment for gender dysphoria and not be bound to specific publications—and future versions of those publications that do not yet exist.

2. Plaintiffs' proposed permanent injunctive relief.

Under Fed. R. Civ. P. 65(d), an injunction must "state its terms specifically," and "describe in reasonable detail–and not by referring to the complaint or other document–the act or acts restrained or required." Fed. R.

Civ. P. 65(d)(1)(B) and (C). Again, Defendants submit that declaratory relief is sufficient here and no injunction is necessary. But even if this Court is inclined to issue injunctive relief, the Plaintiffs' proposals do not meet Rule 65(d)'s requirements because they are overly broad, vague, incorporate other documents, and go beyond the scope of the Court's findings in this case.

a. Section II.A.1.

In Section II.A.1. of their proposal, Plaintiffs request an injunction ordering that:

> Defendants are further permanently enjoined from adopting or enforcing any regulation, policy, practice, procedure, or guidance with the purpose or effect of categorically excluding coverage for any gender-confirming treatment recognized as a treatment for gender dysphoria by the prevailing standards of care (including, but not limited to, excluding coverage for any medically necessary treatment for gender dysphoria based on a designation of that treatment as "cosmetic"), or subjecting any such treatment to more stringent review or prior authorization requirements than the same treatments when intended or used to treat any condition other than gender dysphoria.

First, this request for relief is overbroad because it is untethered from the discrimination theory that underlies this Court's summary judgment decision, as well as the confines of the Challenge Exclusion. It asks this Court to forbid Defendants from categorically denying coverage for any gender dysphoria treatment, regardless of whether DHS covers those treatments when prescribed for other diagnoses, and regardless of whether they were prohibited under the Challenged Exclusion. This Court did not hold that the Affordable Care Act, Medicaid Act, and Equal Protection Clause require

coverage of gender dysphoria treatments in a vacuum—it held that those federal laws require coverage of gender-confirming surgery and hormones *when those same treatments are covered for other reasons*.

For instance, the WPATH guidelines state that penile prostheses can help alleviate gender dysphoria. (WPATH Guidelines 10.) WPATH also notes that an acceptable gender-confirming treatment for female-to-male transsexuals is "implantation of erection and/or testicular prostheses." (WPATH Guidelines 57.) However, both penile and testicular protheses are expressly excluded from coverage for *all* Medicaid beneficiaries under Wis. Admin. Code DHS § 107.03(25) and (26). For such treatments, there is no discrimination between beneficiaries with gender dysphoria and those without—no one receives coverage. This is just one example of how Plaintiffs' remedial scheme exceeds both the Court's liability determination and the scope of the Challenged Exclusion.

Second, this request is vague because it is unclear to what conduct it would apply. "Since an injunctive order prohibits conduct under threat of judicial punishment, basic fairness requires that those enjoined receive explicit notice of precisely what conduct is outlawed." *Schmidt v. Lessard*, 414 U.S. 473, 476 (1974). This case was about a clear, written policy: a Medicaid coverage exclusion expressly stated in administrative code provisions. This case was not, however, about a pattern or practice of individual coverage

decisions or when individual coverage decisions can amount to unlawful discrimination under federal law. Like any medical treatment, Defendants (or HMOs who help administer Wisconsin Medicaid), might decide in a particular case that a prescribed gender dysphoria treatment is not medically necessary and thus that coverage should be denied. Similar decisions are made all the time in the insurance industry, but under Plaintiffs' requested injunction, it is not clear when those decisions in the gender dysphoria context would amount to an enjoined "practice . . . with the . . . effect of categorically excluding coverage for any gender-confirming treatment recognized as a treatment for gender dysphoria" or "subjecting any such treatment to more stringent review or prior authorization requirements than the same treatments when intended or used to treat any condition other than gender dysphoria." (*See* Dkt. 225-1:4–5.)

Third, incorporating "prevailing standards of care" that are, themselves, vague fails to provide fair notice to Defendants of what specific action is required. An injunction must be embodied in a standalone separate document that spells out within its four corners exactly what the enjoined parties must or must not do. *Auto Driveaway Franchise Sys., LLC v. Auto Driveaway Richmond, LLC*, 928 F.3d 670, 676 (7th Cir. 2019). Plaintiffs clearly violate this basic requirement throughout their proposal for a permanent injunction. Not only do they seek to incorporate WPATH and Endocrine Society guidelines,

they seek an order incorporating "future versions of [these] documents." (Dkt. 225-1:3.) This is impermissible under Rule 65(d)(1)(C).

Fourth, the WPATH and Endocrine Society guidelines do not clearly articulate all surgical treatments that are recognized as treatment for gender dysphoria. For example, WPATH states that these "may include . . . various aesthetic procedures." (WPATH Guidelines 57.) And the Endocrine Society notes that its guidelines "should not be considered inclusive of all proper approaches." (Endocrine Society Guidelines 3895.) Plaintiffs' proposed order incorporating vaguely-articulated documents violates Rule 65(d)(1)(B).

b. Section II.A.2.

In Section II.A.2. of their proposal, Plaintiffs request the following injunction:

> Defendants shall ensure that Wisconsin Medicaid covers all gender-confirming treatments recognized by the prevailing standards of care for the treatment of gender dysphoria. A treatment will be presumed to be medically necessary for any beneficiary who meets the clinical eligibility criteria set forth in the prevailing standards of care for the requested treatment or service. Wisconsin Medicaid may not impose more onerous eligibility criteria for receiving a gender-confirming treatment than those contained in the prevailing standards of care for that treatment. Individual approvals will remain subject to Wisconsin Medicaid's standard prior authorization procedures, where applicable.

For all the same reasons as in Argument II(C)(2)(a) above, this proposed injunction is also overly broad, vague, exceeds the scope of the Challenged

Exclusion and the Court's findings on liability, and violates the requirements of Rule 65(d)(1)(B) and (C).

Additionally, this provision seems to require Defendants to presume the medical necessity of any procedure recognized by the WPATH and Endocrine Society guidelines as gender dysphoria treatment. This is contrary to the Court's finding that "many transgender people who are diagnosed with gender dysphoria will not require surgery." (Dkt. 217:5.) Quoting the WPATH guidelines, the Court found that "[w]hile most professionals agree that genital surgery and mastectomy cannot be considered purely cosmetic, opinions diverge as to what degree other surgical procedures (e.g., breast augmentation, facial feminization surgery) can be considered purely reconstructive." (Dkt. 217:5.) The WPATH guidelines go on to discuss these various procures, explaining that

> [a]lthough most of these procedures are generally labeled "purely aesthetic," these same operations in an individual with severe gender dysphoria can be considered medically necessary, depending on the unique clinical situation of a given patient's condition and life situation. This ambiguity reflects reality in clinical situations, and allows for individual decisions as to the need and desirability of these procedures.

(WPATH Guidelines 64.) Thus, neither the Court's findings nor the WPATH guidelines support a presumption of medical necessity for surgical procedures to treat gender dysphoria. Rather, individual authorization requests for these procedures should be subject to DHS's standard review, prior authorization

procedures, and determinations for medical necessity per Wis. Admin. Code DHS § 101.03(96m).

To be clear, Defendants are not contending that these surgical procedures for gender dysphoria are *never* medically necessary—this Court clearly resolved that question to the contrary. But Defendants object to any injunction that seemingly requires it to find that these procedures are *always* medically necessary to treat gender dysphoria. That would render gender dysphoria treatments unlike any other category of treatments covered by Wisconsin Medicaid. All treatments—whether surgical treatments for gender dysphoria or anything else—are sometimes medically necessary, and sometimes not. That decision must be left to the independent judgment of DHS medical professionals, not made by a court-imposed injunction.

c. Section II.A.3.

In Section II.A.3., Plaintiffs request an order that:

> Within 120 days of this Order, Defendants will publish clinical coverage criteria for gender-confirming treatments for use by DHS staff and Wisconsin Medicaid HMOs involved in making coverage determinations, consistent with paragraphs II.A.1.-2. above, and will promptly disseminate those guidelines to all DHS staff involved in the administration of Wisconsin Medicaid and all Wisconsin Medicaid HMOs. Subsequently, Defendants will provide a copy of those guidelines to all new DHS employees involved in the administration of Wisconsin Medicaid and all new Wisconsin Medicaid HMOs.

In addition to the objections noted above regarding Plaintiffs' definition of "gender-confirming treatments" and the proper scope of injunctive relief in

this case, this proposed injunction is vague and overly broad. Namely, it is not necessary to order DHS to provide a copy of any new clinical policy to "all new DHS employees involved in the administration of Wisconsin Medicaid and all new Wisconsin Medicaid HMOs."

"[I]njunctive relief should be 'no broader than necessary to cure the effects of the harm caused by the violation' . . . ." *Church & Dwight Co. v. SPD Swiss Precision Diagnostics, GmBH*, 843 F.3d 48, 72 (2d Cir. 2016) (citations omitted). Here, there are hundreds of DHS employees that, though they work for the Medicaid program, are not involved in benefits administration and would have no need for clinical policies. This also true for new DHS employees who know nothing of the past Challenged Exclusion. (*See* Appleby Decl. ¶ 15.) Similarly, any new Medicaid HMOs will receive notice of this coverage policy during contract negotiations, so there is no need to provide them another notice. (*Id.*) These provisions are not necessary to cure the effects of the Challenged Exclusion—these individuals and HMOs never worked under the Challenged Exclusion. As such, they should not be included in any injunctive relief.

Additionally, while it would be possible to develop a coverage policy within 120 days, it would take at least 180 days for DHS to fully integrate the policy into the Medicaid program and meet its legal requirements for guidance documents under Wis. Stat. § 227.112. (Appleby Decl. ¶¶ 8–9.)

d. Sections II.A.4. and 5.

In Sections II.A.4. and 5. of their proposal, Plaintiffs request that the following be included in the Court's permanent injunction:

> 4. DHS may, in its discretion, promulgate regulations, publish guidance, or issue other materials regarding coverage for gender-confirming treatments, provided that such regulations, guidance documents, or other materials are consistent with the terms of paragraphs II.A.1.-2. above. However, the issuance of such regulations or guidance materials shall not delay the ability of Class Members to request and receive approval for necessary gender-confirming treatments.
>
> 5. To comply with this Order, DHS may amend and/or enter into new contractual agreements with Wisconsin Medicaid HMOs, provided that such contracts are consistent with the terms of paragraphs II.A.1.-2. above. However, the negotiation or execution of new or amended contracts with Wisconsin Medicaid HMOs shall not delay the ability of Class Members to request and receive approval for necessary gender-confirming treatments.

Incorporating the previous objections, Defendants further object to these proposed provisions because they are discretionary, making them unnecessary. The Court should not order injunctive relief that is broader than necessary, or that imposes unnecessary burdens. *Church & Dwight,* 843 F.3d at 72.

3. Notice Requirements.

Plaintiffs' proposal also includes detailed notice provisions, requiring Defendants to draft and issue notice to Medicaid HMOs, participating medical providers, social service organizations, and a *ForwardHealth Update*—each containing detailed information regarding the Court's order and these entities' obligations under the order. Defendants incorporate the previous objections to

Plaintiffs' remedial plan, as a whole, and the specific objections noted above to the definitions and proposed injunction provisions that are also reflected in the proposed notice requirements.

Although there is not a justification for this Court to impose it, DHS voluntarily will provide notice of the Court's final judgment in this case to Medicaid HMOs, issue a clarifying *ForwardHealth Update,* and notify medical providers and social service providers of the change in coverage for gender-confirming treatments with the removal of the Challenged Exclusion. These notices will reflect that Medicaid-enrolled patients, clients, or constituents may be eligible to request coverage for gender-confirming treatments and services that were previously excluded from coverage under the Challenged Exclusion, and previously may have been denied. And to the extent the notices must contain any further direction, they should reflect the proper process—that individual authorization requests for these procedures should be subject to DHS's standard review, prior authorization procedures, and determinations for medical necessity per Wis. Admin. Code DHS § 101.03(96m).

In Section III.E.1.–2., Plaintiffs also seek an order requiring DHS to:

> 1. [I]dentify (a) all current Wisconsin Medicaid beneficiaries denied coverage for one or more gender-confirming treatments by DHS and/or a Wisconsin Medicaid HMO since January 1, 2014; and (b) all medical providers who submitted prior authorization requests for Wisconsin Medicaid coverage for a gender-confirming treatment that were denied by DHS and/or a Wisconsin Medicaid HMO since January 1, 2014; and

> 2. [U]sing the form notices attached as Appendix B to this Order, notify each such beneficiary and provider in writing, through their preferred contact method (i.e., mail, email), of: (a) the terms of this Order; (b) the right of the individual and/or provider to submit prior authorization requests for gender-confirming treatments that were previously denied; (c) the individual's right to seek the assistance of counsel regarding the individual's rights under this Order; and (d) the contact information for Class Counsel.

However, the requirement that DHS "identify" all current Medicaid beneficiaries who were denied coverage under the Challenge Exclusion since January 2014, along with all medical providers who submitted prior authorizations for this type of coverage, is vague, onerous, and impractical. This is because most of these individuals and medical providers are unknown to DHS. Except for fee-for-service beneficiaries or those involved in the DHS grievance process, the prior authorization requests were made to and denied by the Medicaid HMOs without ever being reported to DHS. (Appleby Decl. ¶ 19.) Identifying these individuals and providers would be difficult (Appleby Decl. ¶ 20), and Plaintiffs' proposal does not describe in reasonable detail the actions DHS is required to take to abide by this provision.[1] As such, this notice proposal violates Rule 65(d)(1)(C).

[1] Plaintiffs suggest that DHS model its effort to identify these beneficiaries and medical providers after the efforts they took in subpoenaing this information from 16 Medicaid HMOs. (Dkt. 226:19 n.3.) To abide by the requirements of Rule 65(d)(1)(C), these actions must be described in reasonable detail in the Court's order, and DHS should be provided with sufficient time to obtain information from outside sources, review that information (which appears to be substantial), ascertain both the identity of the beneficiary and the medical provider who submitted the prior authorization request, and issue the proper notice.

Looking specifically at Plaintiffs' Appendix B, which includes their proposed notices to individuals and medical providers, Defendants object to the following statement, for the reasons previously discussed concerning the definition of the "prevailing standards of care":

> On [DATE], 2019, the Court further ordered Wisconsin Medicaid to cover surgical and hormone treatments for gender dysphoria when medically necessary under the prevailing standards of care for the treatment of gender dysphoria.

(Dkt. 225-1:12 ¶ 3; Dkt. 225-1:13 ¶ 3.) Defendants also object to the following provision in Appendix B:

> Now, requests must be reviewed to determine whether the series requested are medically necessary under the prevailing standards of care for the treatment of gender dysphoria.

(Dkt. 225-1:12 ¶ 4; Dkt. 225-1:13 ¶ 4) Not only is this provision inappropriate for the reasons already discussed, it also fails to reflect the proper process—that individual authorization requests for these procedures will be subject to DHS's standard review, prior authorization procedures, and determinations for medical necessity per Wis. Admin. Code DHS § 101.03(96m).

Lastly, any timeline to issue these notices must take into account the requirements of Wis. Stat. § 227.112. DHS has indicated that they can accomplish this in 90 days after any notice is finalized. (Appleby Decl. ¶ 21.)

4. Reporting and Compliance Requirements.

Finally, Section IV of the Plaintiffs' proposal includes both a 180-day and 1 1/2 year reporting requirement where DHS must submit a detailed report containing (1) a detailed summary of all actions taken to comply with the Court's order; (2) a copy of the coverage policy for previously excluded gender-confirming treatments; (3) a copy of all materials regarding Medicaid coverage for gender-confirming treatments issued by DHS; (4) a copy of any notices sent by DHS to medical providers and social organizations, and a list of those receiving the notice; (5) a statement as to the number of individuals and providers who were previously denied coverage under the Challenge Exclusion who received a notice by DHS. Defendants submit that any reporting requirements are unnecessary and, therefore, outside the scope of injunctive relief.

Plaintiffs have offered no evidence suggesting that Defendants will fail to comply with the declaratory and injunctive relief included in the decision this Court already entered. In fact, it is DHS's objective to provide Wisconsin Medicaid beneficiaries with medically necessary covered services for the treatment of gender dysphoria. (Appleby Decl. ¶ 6.) The Court acknowledged that even while the Challenged Exclusion was in place, DHS sporadically covered some gender-confirming surgery under another regulation. (Dkt. 217:12.) DHS clinical staff also sought out ways to cover gender-

confirming treatment. They opined that the Challenged Exclusion violated federal law, asked that gender-confirming treatments be approved, and sought to prepare an appropriate policy. (Dkt. 217:12–14.)

"Any reporting provision entered by the district court should be tailored to fit within the scope of the litigation." *Thomas,* 978 F.2d at 510. Here, there have been no findings that DHS and its current administration will fail to adhere to any declaration or order by the Court concerning coverage for gender-confirming surgeries and hormones. Absent this showing, any compliance reporting requirements are not necessary and should not be ordered by the Court.

CONCLUSION

For the reasons stated above, Defendants request that the Court reject Plaintiffs' remedial plan and proposal for equitable relief and issue declaratory relief as set forth in Defendants' proposal. (Dkt. 223.)

Dated this 24th day of September, 2019.

Respectfully submitted,

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